U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 March 2006

Case No.: 2004-BLA-6574

In the Matter of:

LEAMON HAMILTON
Claimant

v.

BLACKFIELD COAL COMPANY, INC.
Employer

KY COAL PRODUCERS SELF-INSURANCE FUND
Carrier

and

DIRECTOR,OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Joseph E. Wolfe, Esq.
For the Claimant

David H. Neeley, Esq.
For the Employer/Carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER – GRANTING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the "Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

Mr. Leamon Hamilton, represented by counsel, appeared at the formal hearing held October 18, 2005 in Pikeville, Kentucky. I afforded both parties the opportunity to offer testimony, question witnesses and introduce evidence; however, Claimant chose not to testify. Thereafter, I closed the record. I based the following Findings of Fact and Conclusions of Law upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. Although the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformity with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, EX and CX refer to the exhibits of the Director, Employer and Claimant, respectively.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Claimant filed his first application for Federal black lung benefits on July 1, 1991 and it was denied by the District Director. (DX 1). Claimant did not appeal this finding. However, on February 12, 2001, Claimant filed a subsequent claim. (DX 2-270). The claim was denied by the District Director on May 10, 2002, on the basis that Claimant failed to prove he was totally disabled. (DX 2-16). Claimant did not appeal this decision. He filed the instant subsequent claim for benefits on June 30, 2003. (DX 4). The District Director awarded Claimant benefits on April 9, 2004. (DX 31). Employer then requested a formal hearing and the claim was transferred to the Office of Administrative Law Judges. (DX 32, 38).

Factual Background

Claimant, Leamon Hamilton, was born on June 17, 1940. (DX 4). Claimant has a fourth grade education. (DX 4). He is married to Hannah Blankenship Hamilton. (DX 4). Claimant alleges that he worked thirty-two years in coal mine employment. (DX 4). His jobs included shooting coal, mechanic, scooper operator, roof bolter helper and coal buggy driver. (DX 4). Claimant left the mines on March 12, 1991. (DX 4). He states he left due to doctor's orders. (DX 4). Claimant chose not to testify at the hearing, but he submitted an employment questionnaire where he stated that his last coal mine employment required lifting and carrying at least fifty pounds throughout the day. (DX 4). Therefore, I find Claimant's last coal mine employment involved heavy manual labor.

Claimant chose not to testify at the hearing and asked for a decision based on the formal record. (Tr. 12). Therefore, when making a smoking determination I must rely exclusively on the medical opinions of record. However, the medical evidence regarding Claimant's smoking

history is contradictory. The record contains inconsistent evidence regarding Claimant's smoking history, and therefore, I am unable to make a smoking determination at this time.

Current Contested Issues

The parties contest the following issues regarding this claim:

1. Whether Claimant's claim was timely filed;

2. Length of coal mine employment;

3. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;[1]

4. Whether Claimant's pneumoconiosis, if present, arose out of coal mine employment;

5. Whether Claimant is totally disabled;

6. Whether Claimant's total disability, if present, is due to pneumoconiosis;

7. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c), (d).

Dependency

Claimant alleges one dependent for the purposes of benefit augmentation, namely his wife, Hannah. (DX 4). They married on December 13, 1960. (DX 4). The parties have not contested dependency. Accordingly, I find that the evidence of record supports a finding that Claimant has one dependent for the purposes of benefit augmentation.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The District Director in this claim made a finding of twenty-five years in coal mine employment. (DX 31). The documentary evidence includes Claimant's Social Security earnings report and an employment questionnaire. In the prior claim, the District Director made a finding of twenty-one years in coal mine employment. Claimant did not appeal this finding. (DX 2-17). I find that Claimant is now bound by the finding of twenty-one years in coal mine employment. The evidence of record supports this finding and at the hearing the parties stipulated to twenty plus years in coal mine employment. Accordingly, based upon all the evidence in the record, I find that Claimant was a coal miner, as that term is defined

[1] In Claimant's prior claim filed February 12, 2001, the District Director found that Claimant suffered from pneumoconiosis arising out of his coal mine employment. (DX 2-16). However, the District Director denied the claim based on Claimant's failure to prove total disability. (DX 2-16). The District Director's decision has become final and binding due to the parties' failure to appeal. Accordingly, Claimant has established pneumoconiosis arising out of coal mine employment. Therefore, since this is a subsequent claim the issues of pneumoconiosis and pneumoconiosis arising out of coal mine employment will only be reexamined if Claimant proves a change in physical condition. Only then will I reopen the record and go through all the issues of entitlement.

by the Act and Regulations, for twenty-one years. He last worked in the Nation's coal mines in 1991. (DX 4).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

Claimant filed two previous claims for benefits on July 1, 1991 and February 12, 2001. In order for a medical opinion report to constitute notice, it must be a well-reasoned opinion that Claimant was totally disabled due to pneumoconiosis. The medical opinion reports are discussed below. However, the opinion of Dr. Rasmussen is the only medical opinion of record which is well-reasoned and well-documented on the issue of totally disability due to pneumoconiosis. (DX 10, CX 1). His medical opinions were issued August 5, 2003 and July 7, 2004.

Therefore, I find that Employer has not rebutted the presumption of § 725.308(c), and that this claim was timely filed. Furthermore the fact that the medical report of Dr. Rasmussen is in the record, does not mean the communication requirement is satisfied. I am not inclined to assume that simply because a medical report was in the record or in the possession of Claimant's attorney, that the findings were "communicated" to Claimant. In fact, the presumption under §725.308(c) is that every claim is timely. Assuming that access to a report equates to communication by a physician would severely undermine §725.308(c). Therefore, even if I had found the other medical reports of record well-reasoned and well-documented as to total disability due to pneumoconiosis, there is no evidence in the record to indicate the reports were ever communicated to Claimant. Furthermore, Claimant did not testify at the hearing and there are no interrogatories or deposition testimony which indicates Claimant was ever informed he was totally disabled due to pneumoconiosis with a well-reasoned and well-documented opinion. When Claimant filed his claim, he did indicate that a doctor ordered him to leave coal mine employment due to his lung condition. (DX 4). However, this opinion is not in the record and I have no way of determining whether the doctor had a well-reasoned and well-documented opinion that Claimant is totally disabled due to pneumoconiosis

Therefore, concerning timeliness, I have found that the opinion of Dr. Rasmussen is the only well-reasoned and well-documented opinion in relation to totally disability due to pneumoconiosis. In addition, I have found that there is no evidence of record indicating that such diagnoses were communicated to Claimant. Accordingly, this claim was timely filed.

Threshold Issue for Subsequent Claims

Under the amended regulations of the Act, the progressive and irreversible nature of pneumoconiosis is acknowledged. 20 C.F.R. § 718.201(c). Consequently, claimants are permitted to offer recent evidence of pneumoconiosis after receiving a denial of benefits. *Id.* The new regulations provide that where a claimant files a subsequent claim more than one year after a prior claim has been finally denied, the subsequent claim must be denied on the grounds of the prior denial unless "Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d). If a claimant establishes the existence of an element previously adjudicated against him, only then must the administrative law judge consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits. *Id.* A duplicate claim will be denied unless Claimant shows that one of the applicable conditions has changed since the date of the previous denial order. *Id; see, also Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994).

Accordingly, because Claimant's previous claim was denied, he now bears the burden of proof to show that one of the applicable conditions of entitlement has changed. 20 C.F.R. § 725.309(d). I must review the evidence developed and submitted subsequent to May 10, 2002, the date of the prior denial, to determine if he meets this burden. *Id.* The following elements were deemed not shown by Claimant as a result of the initial denial: that he is totally disabled due to pneumoconiosis. 20 C.F.R. § 410.410(b).

Medical Evidence

Medical evidence submitted with a claim for benefits under the Act is subject to the requirement that it must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §§ 718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. § 725.414. The regulations provide that a party is limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy and two medical reports as affirmative proof of their entitlement to benefits under the Act. §§ 725.414(a)(2)(i), 725.414(a)(3)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test or arterial blood gas study. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). Likewise, the District Director is subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i-iii). Furthermore, since this is a subsequent claim only evidence submitted after May 10, 2002 will be considered unless a material change in physical condition is proven. 20 C.F.R. § 725.309(d).

Medical Evidence

New X-ray Reports[2]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
CX 2	4/16/01	Robinette	1/1[3]
DX 15	7/29/03	Westerfield B-reader	1/1
DX 10	8/05/03	Patel BCR/B-reader	1/1
DX 14	8/05/03	Halbert BCR/B-reader	0/0
CX 2	7/2/04	Robinette	1/1[4]
CX 1	7/8/04	Patel BCR/B-reader	1/0
CX 2	7/19/05	Robinette	1/1

[2] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a) and (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

[3] Claimant asks the Court to find good cause and admit the April 16, 2001 chest x-ray read by Dr. Robinette into evidence. I have found no good cause for admitting the additional chest x-ray film.

[4] Claimant designates Dr. Robinette's July 2, 2004 chest x-ray as rebuttal evidence; however, there are no other chest x-rays designated that were taken the same date. Rebuttal evidence is used to rebut a physician's interpretation of an x-ray that is submitted by the opposing party. 20 C.F.R. § 725.414(a)(2)ii) and (3)(ii)(2001). Therefore, the July 2, 2004 chest x-ray will not be taken into consideration.

X-ray Reports from Claimant's July 1, 1991

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 1-70	6/05/91	Dr. Myers	1/2
DX 1-69	6/11/91	Dr. Baker B-reader	1/1
DX 1-68	6/12/91	Dr. Anderson	1/0
DX 1-66	8/06/91	Dr. Poulos BCR/B-reader	No abnormalities consistent with pneumoconiosis

X-ray Reports from Claimant's February 12, 2001[5]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 2-113	10/03/91	Lane B-reader	1/0
DX 2-162	03/09/01	Baker[6]	1/0
DX 2-73	05/04/01	Fino B-reader	1/2

New Pulmonary Function Studies[7]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 15 7/29/03	Westerfield	63/ 69"	1.85	3.40	61	54%	Yes	Pre-bronchodilator Good cooperation and effort
			2.02	3.66	63	55%	Yes	Post-bronchodilator Good cooperation and effort
DX 10[8] 8/05/03	Rasmussen	63/ 70"	1.97	3.56	66	55%	Yes	Pre-bronchodilator Good cooperation and effort
			2.17	3.84	87	56.5%	Yes	Post-bronchodilator Good cooperation and effort

[5] The chest x-ray films taken on June 2, 1991, June 5, 1991, and June 11, 1991 were filed in both the first and second claims. When weighing the evidence I will only consider each film once, and as a result, I did not discuss the readings again.

[6] On the March 9, 2001 x-ray film it states that Dr. Baker was not a B-reader at the time the film was read.

[7] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Benefits Review Board (the "Board") has held that a ventilatory study which is accompanied by only two tracings is in substantial compliance with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp*., 12 B.L.R. 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[8] Dr. Burki, Board-certified in Internal Medicine and Pulmonary Diseases validated this pulmonary function study performed by Dr. Rasmussen.

CX 1[9] 7/07/04	Rasmussen	64/ 69"	1.87	3.28	N/A	57%	Yes	Pre-bronchodilator Fails to state Cooperation and effort levels
			1.95	3.54	N/A	55%	Yes	Post-bronchodilator Fails to state cooperation and effort levels

Pulmonary Function Studies from Claimant's July 1, 1991 Claim

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 1-62 6/05/91	Dr. Myers	50/ 70"	2.76	3.57	N/A	77.31	Yes	Doesn't state cooperation and effort levels
DX 1-57 6/11/91	Dr. Baker	50/ 70"	2.05	3.78	91	54	Yes	Doesn't state cooperation and effort levels
DX 1-51 6/12/91	Dr. Anderson	50/ 69.5"	2.23	4.11	87.69	54.24	Yes	Fair cooperation and effort
DX 2-2 8/6/91	Dr. Mettu	51/ 69"	2.05	3.51	75.3	58.4	Yes	Good cooperation and effort

Pulmonary Function Studies from Claimant's February 12, 2001 Claim[10]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 2-134 10/03/91	Lane	51/ 70.5	1.95	3.77	78.4	51.7	No	Good effort
DX 2-189 03/09/01	Baker	60/ 69.25	1.82	2.69	43	67.7	Yes	Poor cooperation
DX 2-182 04/05/01	Baker	60/ 69.25	1.95	3.54	70	55	Yes	Fair cooperation Good understanding[11]
DX 2-56	Fino	60/	2.01	3.38	N/A	59.4	Yes	Good cooperation and understanding

[9] Dr. Rasmussen's July 7, 2004 pulmonary function testing fails to state Claimant's cooperation and understanding level, and therefore, the tests fail to meet regulation requirements. However, in *Crapp v. U.S.Steel Corp.*, 6 B.L.R. 1-476 (1983), the Board held that a non-conforming pulmonary function study may be entitled to probative value where the results exceed the table values, *i.e.*, the test is non-qualifying. Therefore, Dr. Rasmussen's pre-bronchodilator testing which was non-qualifying can be taken into consideration, but the post-bronchodilator testing which produced qualifying results cannot be taken into consideration when determining total disability.

[10] The pulmonary function tests conducted on June 5, 1991, June 11, 1991 and June 12, 1991 were filed in both the first and second claims. I will only weigh them as evidence once, and as a result, since I have already identified them under the tests admitted in the July 1, 1991claim, I will not discuss them in this section.

[11] N.K. Burki, M.D. invalided the testing performed on April 5, 2001. He stated that the ventilatory tests were unacceptable due to the equipment failing to meet proper specifications. Dr. Burki found that the paper speed was too slow.

05/04/01		70						
DX 2-173 05/29/01	Baker	60/ 69.25	2.08	3.82	74	54.45	Yes	Fair cooperation and good understanding

New Blood Gas Studies[12]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise
DX 15	7/29/03	Westerfield	42	37	R
			37	105	E
DX 10[13]	8/05/03	Rasmussen	34	79	R
			36	68	E

Blood Gas Studies from Claimant's July 1, 1991 Claim

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise
DX 1-41[14]	6/05/91	Dr. Myers	41.3	84.2	?
DX 1-57	6/11/91	Dr. Baker	40.3	74.7	R
DX 1-44	8/06/91	Dr. Mettu	39	78.5	R

Blood Gas Studies from Claimant's February 12, 2001 Claim[15]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise
DX 2-134	10/03/91	Lane	37.7	71	R
DX 2-163	03/09/01	Baker	40	68	R
DX 2-56	05/04/01	Fino	36.4	67.8	R

[12] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).
[13] Employer provided a rebuttal opinion from Dr. Fino stating Claimant is not totally disabled. Dr. Fino bases his opinion on his finding that Claimant's last coal mine employment did not involve heavy manual labor.
[14] Although Dr. Myers included the arterial blood gas results in his report, the actual test is not included in the record. Therefore, I cannot take the tests conducted by Dr. Myers into consideration because I am unable to determine whether it complies with regulation quality standards.
[15] The blood gas studies performed on June 5, 1991 and June 11, 1991 were filed in the first and second claims. I will only weigh them as evidence once, and as a result, I will not discuss them again in this section.

New Narrative Medical Evidence

On August 5, 2003, D.L. Rasmussen, M.D., Board-certified in Internal Medicine, performed a department sponsored pulmonary evaluation on Claimant, at which time he took a patient history of symptoms and recorded an employment history in the coal mines for thirty-one years. (DX 10). Dr. Rasmussen noted Claimant had a history of shortness of breath, daily cough, sputum production, dyspnea, orthopnea, wheezing, anterior chest pain, pneumonia, pulmonary tuberculosis, chronic bronchitis, kidney and bladder cancer, high blood pressure and connective tissue disease. He recorded a smoking history of one pack of cigarettes per day for fifteen years. Claimant no longer smokes. After the physical examination of Claimant's lungs, Dr. Rasmussen noted at auscultation Claimant's breath sounds were normal on the right with no rales, rhonchi or wheezes. In addition, Dr. Rasmussen performed a chest x-ray, pulmonary function tests and arterial blood gas studies. (DX 10).

Upon reviewing the results of the examination and tests, Dr. Rasmussen diagnosed Claimant with coal workers' pneumoconiosis 1/0, based on Claimant's chest x-ray and coal dust exposure. (DX 10). He also diagnosed Claimant with chronic obstructive pulmonary disease and emphysema, both based on Claimant's chronic productive cough, airflow obstruction and reduced SBDLCO. Dr. Rasmussen related Claimant's conditions to coal dust exposure and smoking. In Dr. Rasmussen's opinion, Claimant has a moderate loss of lung function and does not retain the pulmonary capacity to perform his last regular coal mine employment which he states required heavy manual labor. He related Claimant's impairment to smoking and coal dust exposure, but stated Claimant's history of coal dust exposure is a major contributing factoring in his impairment. (DX 10).

Dr. Rasmussen examined Claimant again on July 7, 2004. He took a patient history of symptoms and recorded an employment history of thirty-one years in coal mine employment. (CX 1). Dr. Rasmussen noted that Claimant worked as a hand loader, roof bolter helper, mechanic, electrician and operating motors, drills, loading machines, cutting machines and scoops. He also stated Claimant last worked as a shuttle car operator which required Claimant to carry heavy tools weighing fifty to seventy pounds. Dr. Rasmussen found that Claimant's coal mine employment required him to perform considerable heavy manual labor. He also recorded Claimant's symptoms, finding a history of wheezing, shortness of breath, dyspnea and chronic cough. In addition, Dr. Rasmussen performed a chest x-ray, pulmonary function tests, arterial blood gas studies and physical examination on Claimant. Dr. Rasmussen noted Claimant's chest exam revealed minimally reduced breath sounds on the right and markedly reduced sounds on the left with coarse persistent rales over the left upper zone. (CX 1).

After reviewing the results of the examination and tests, Dr. Rasmussen diagnosed Claimant with coal workers' pneumoconiosis based on Claimant's chest x-ray and history of coal dust exposure. He also found Claimant suffered from minimal resting hypoxia and a moderate, slightly reversible obstructive ventilatory impairment both based on the objective testing. He opined that Claimant has a moderate loss of lung function as reflected by the ventilatory impairment in oxygen transfer during very light exercise. Dr. Rasmussen states that Claimant does not retain the pulmonary capacity to perform his last coal mine employment. (CX 1).

Emory Robinette[16] examined Claimant on July 19, 2005, at which time he reviewed the Claimant's symptoms and recorded an occupational history. (CX 2). Dr. Robinette noted that Claimant worked thirty-one years in coal mine employment as a mechanic and shuttle car operator. Claimant complained of chronic cough, shortness of breath, sputum and increased orthopnea. The physician stated Claimant started smoking when he was a teenager and quit when he was forty-five. He recorded a thirty pack-year smoking history. Upon physical examination of Claimant's chest, Dr. Robinette noted expanded symmetrically with inspiration and expiration. He found diminished breath sounds and a few expiratory wheezes. He then performed a chest x-ray, pulmonary function tests and arterial blood gas studies on Claimant. (CX 2).

Dr. Robinette diagnosed Claimant with pneumoconiosis based on the chest x-ray data and mild obstructive lung disease based on the objective testing. He opines that Claimant has an occupational lung disease from his coal mine employment resulting in an associated respiratory impairment and significant reduction of his diffusing capacity. However, Dr. Robinette never makes a finding concerning whether Claimant has the respiratory capacity to return to his past coal mine employment. (CX 2).

B.T. Westerfield, Board-certified in Internal Medicine and Pulmonary Diseases, submitted a consultative report on August 30, 2004. (EX 1). He states that he previously examined Claimant on July 29, 2003. Dr. Westerfield reviewed the medical reports of Dr. Dennis H. Halbert and the evaluation by Dr. Rasmussen when formulating his opinion. Dr. Westerfield opined that Claimant suffers from pneumoconiosis based on the chest x-ray evidence. He also diagnosed Claimant with chronic obstructive pulmonary disease and tuberculosis. Based on the spirometry results, he finds that Claimant has a respiratory impairment related to smoking. Dr. Westerfield states that it is difficult to attribute Claimant's impairment to coal mine employment because Claimant's exposure ceased over thirteen years ago and the pattern of Claimant's respiratory impairment is that seen due to cigarette smoking. Therefore, Dr. Westerfield opines that Claimant's impairment is unrelated to pneumoconiosis. (EX 2).

Dr. Westerfield reiterates his opinion in his deposition taken September 5, 2003. (DX 15). He testifies that Claimant has the respiratory capacity to perform his past coal mine employment. Dr. Westerfield found Claimant's past coal mine employment included cutting and loading coal and operating machinery. Dr. Westerfield could not state whether Claimant was required to perform heavy lifting. He opined that Claimant could operate equipment but not perform arduous labor.

Gregory Fino, Board-certified in Internal Medicine with a Subspecialty in Pulmonary Diseases, submitted a consultative report on January 9, 2004. (DX 12). Dr. Fino noted that he had previously examined Claimant in May 2001. When formulating his opinion in this report he examined the medical evidence of record. Dr. Fino diagnosed Claimant with pneumoconiosis and a mild to moderate respiratory impairment. However, he opines that Claimant has the respiratory capacity to perform his prior coal mine employment. Dr. Fino bases this opinion on his finding that Claimant's past coal mine employment did not involve heavy manual labor. He

[16] Dr. Robinette's qualifications are not included in the record.

noted that Claimant worked thirty-one years in coal mine employment as a mechanic and running a buggy. Dr. Fino states that when taking into consideration the other medical evidence of record, his opinion remains the same. (DX 12).

Narrative Medical Evidence from Claimant's July 1, 1991 Claim

John E. Myers, M.D. examined Claimant on June 5, 1991. (DX 1-38). He recorded Claimant had an employment history of thirty years in the underground coal mines. Dr. Myers stated Claimant worked loading and cutting coal and as a shuttle car operator. He stated that Claimant informed him that he had only smoked as a teenager. Dr. Myers noted Claimant had a history of tuberculosis, dyspnea, shortness of breath, cough, sputum production and wheezing. Upon physical examination, Dr. Myers found that Claimant's breathe sounds revealed wheezing and air exchange impairment. He also performed a chest x-ray, pulmonary function testing and arterial blood gas studies. Dr. Myers diagnosed Claimant with pneumoconiosis based on the chest x-ray, tuberculosis and chronic obstructive pulmonary disease. He opined that Claimant has a pulmonary impairment based on all his pulmonary conditions. Dr. Myers states that Claimant is unable to perform his prior coal mine employment. (DX 1-38).

Glen Baker, M.D. examined Claimant on June 11, 1991. (DX 1-31). He found that Claimant worked thirty years in coal mine employment, operating the loading machine, cutting machine, roof bolter and shuttle car. Dr. Baker noted Claimant smoked one pack of cigarettes per day for four or five years, but that he had quit smoking twenty-five years ago. Dr. Baker stated that Claimant had a history of cough, sputum production, shortness of breath and wheezing. Upon examination, Dr. Baker noted Claimant's lungs were clear with no rales or wheezes. He also performed a chest x-ray, pulmonary function tests and arterial blood gas studies. Dr. Baker diagnosed Claimant with pneumoconiosis based on the chest x-ray and history of coal dust exposure; mild resting hypoxemia based on the arterial blood gas exam; chronic obstructive pulmonary disease based on Claimant's history; and, old pulmonary tuberculosis based on Claimant's history. Dr. Baker opined that Claimant has a pulmonary impairment related to coal dust exposure and the possible scarring effects of his old pulmonary tuberculosis. Dr. Baker further stated that Claimant is unable to perform his regular coal mine employment. He states that Claimant should have no further exposure due to his pneumoconiosis, chronic obstructive airway disease, chronic bronchitis and resting arterial hypoxemia. Dr. Baker opines that Claimant would have a difficult time performing manual labor on an eight hour basis due to these conditions. (DX 1-31).

William H. Anderson, M.D. examined Claimant on June 12, 1991. (DX 1-25). Dr. Anderson recorded an employment history of thirty years in the underground coal mines. He noted that Claimant used to smoke. Dr. Anderson noted Claimant had a history of shortness of breath, cough and tuberculosis. He performed a physical examination, chest x-ray and pulmonary function tests on Claimant. Dr. Anderson diagnosed Claimant with pneumoconiosis, moderate obstructive ventilatory defect, previously healed tuberculosis and arteriosclerotic heart disease. He opined that Claimant has an occupational lung disease and does not have the ventilatory capacity to perform all jobs in coal mining. (DX 1-25).

R.V. Mettu, M.D. examined Claimant on August 6, 1991. (DX 1-17). Dr. Mettu stated that Claimant had a history of wheezing and tuberculosis. He noted that Claimant smoked a half a pack of cigarettes per day between 1955 and 1958 and worked thirty years in coal mine employment. Claimant's present symptoms included sputum production, wheezing, dyspnea, cough, chest pain, orthopnea, paroxysmal nocturnal dyspnea and shortness of breath after climbing one flight of stairs. Dr. Mettu also performed a physical examination, chest x-ray, pulmonary function tests and arterial blood gas studies on Claimant. Upon auscultation, Dr. Mettu noted good air entry in both lung fields and vesicular breathing without adventitious sounds. He diagnosed Claimant with chronic bronchitis. He opined Claimant does not have pneumoconiosis based on the chest x-ray data. Dr. Mettu also stated that Claimant has a moderate pulmonary impairment based on the pulmonary function testing. However, Dr. Mettu failed to state whether Claimant could perform his regular coal mine employment. (DX 1-17).

Narrative Medical Evidence from Claimant's February 12, 2001 Claim[17]

Emery Lane, M.D. examined Claimant on October 3, 1991. (DX 2-129). He recorded an employment history of thirty-one years in the underground coal mines working as a mechanic, coal driller and buggy operator. Dr. Lane noted Claimant had a history of shortness of breath upon exertion, trouble sleeping, some ankle edema and tuberculosis. He stated that Claimant only smoked a few cigarettes as a teenager. Dr. Lane performed a physical examination, chest x-ray, pulmonary function tests and arterial blood gas studies. Upon examination, Claimant's chest revealed equal bilateral expansion and clear lungs. Dr. Lane diagnosed Claimant with heart disease, chronic obstructive pulmonary disease, pulmonary tuberculosis and pneumoconiosis. He opines that Claimant does not have the pulmonary capacity to perform his past coal mine employment due to his chronic obstructive pulmonary disease. (DX 2-129).

On March 9, 2001, Dr. Baker performed a department-sponsored pulmonary evaluation on Claimant. (DX 2-165). He documented an employment history of thirty-one years in underground coal mine employment working as a mechanic, driller operator and cutter. Dr. Baker noted that Claimant smoked off and on between 1958 and 1960 at a rate of one pack of cigarettes per day. He stated Claimant suffered from symptoms including sputum production, wheezing, dyspnea, cough, orthopnea, ankle edema and paroxysmal nocturnal dyspnea. Dr. Baker performed a physical examination, chest x-ray, pulmonary function tests and arterial blood gas studies on Claimant. Upon examination, Claimant's chest revealed decreased breath sounds. Dr. Baker diagnosed Claimant with pneumoconiosis based on chest x-ray evidence and Claimant's history of exposure; chronic obstructive pulmonary disease with a moderate obstructive defect based on the pulmonary function testing; bronchitis based on Claimant's history of cough, sputum production and wheezing; hypoxemia based on the arterial blood gas studies; old tuberculosis based on history; and, possible left ventricular dysfunction based on history. He related Claimant's pneumoconiosis, chronic obstructive pulmonary disease, bronchitis, and hypoxemia to coal mine employment. Dr. Baker opined that Claimant has a moderate impairment based on his decreased FEV_1 readings, bronchitis, low PO_2 level, pneumoconiosis and old tuberculosis. He related the impairment to pneumoconiosis and

[17] The June 5, 1991 exam conducted by Dr. Myers, the June 11, 1991 exam conducted by Dr. Baker and the June 12, 1991 exam conducted by Dr. Anderson were all filed in both the first and second claims. Therefore, since I have already summarized the reports I will not discuss them under this heading.

possible smoking history. Dr. Baker opined Claimant cannot return to coal mine employment due to his pulmonary function testing; however, he notes the testing was not reproducible. (DX 1-165).

Dr. Fino examined Claimant on May 4, 2001 and examined the other medical evidence in the record. (DX 2-54). He noted that Claimant worked thirty-one years in coal mine employment as a mechanic and shuttle car operator. Dr. Fino states that Claimant indicated his past coal mine employment did not require heavy manual labor. He also found that Claimant smoked one pack of cigarettes per day between 1958 and 1960. Dr. Fino noted that Claimant's symptoms included shortness of breath and dyspnea upon exertion. He stated Claimant had a history of headaches, lung problems, chronic stomach problems and tuberculosis. Dr. Fino performed a physical examination, chest x-ray, pulmonary function tests and arterial blood gas studies on Claimant. Upon examination, Claimant's lungs revealed bilateral wheezes. Dr. Fino diagnosed Claimant with pneumoconiosis based on the chest x-ray evidence. He found that Claimant's spirometry revealed a moderate obstruction with no bronchodilator response. The physician stated that Claimant's total lung capacity was normal with a decreased diffusing capacity. He opined Claimant has a respiratory impairment. However, Dr. Fino believes Claimant has the respiratory capacity to perform his prior coal mine employment which did not include heavy manual labor. (DX 2-54).

Hospital and Treatment Records

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), "any record of a miner's hospitalization for respiratory or pulmonary or related disease may be received into evidence." 20 C.F.R. § 725.414(a)(4). Furthermore, a party may submit other medical evidence reported by a physician and not specifically addressed under the regulations under Section 718.107, such as a CT scan. However, there are no hospital or treatment records within the record.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations a claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. § 725.202(d)(2)(i-iv). Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989). However, this is a subsequent claim, and therefore, Claimant must establish a material change in condition as to one of the elements of entitlement not previously established. In Claimant's February 12, 2001 claim, the District Director found pneumoconiosis arising out of coal mine employment. The 2001 decision has become a final order. Therefore, I will only examine total disability to determine whether a material change in condition has occurred. If Claimant proves total disability based on the new evidence, I will then reopen the record and reevaluate all the elements of entitlement.

Total Disability Analysis Based on the Newly Submitted Evidence

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991). A claimant can be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if in absence of contrary probative evidence, the evidence meets one of the Section 718.204(b)(2) standards for total disability. The regulation at Section 718.204(b)(2) provides the following criteria to be applied in determining total disability: 1) pulmonary function studies; 2) arterial blood gas tests; 3) a cor pulmonale diagnosis; and/or, 4) a well-reasoned and well-documented medical opinion concluding total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

A. Pulmonary Function Tests

Under Section 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests.[18] To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited a poor cooperation or comprehension. *See, e.g., Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984). However, a non-conforming study may be entitled to probative weight where the results are non-qualifying. The Board has stated that a report's lack of cooperation and comprehension statements does not lessen the reliability of the study when it is non-qualifying.

[18]A qualifying pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A non-qualifying test produces results that exceed the table values.

In the pulmonary function tests of record, there is a small discrepancy in the height attributed to Claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). In analyzing the pulmonary function test results, I shall utilize the average height reported for Claimant, 69.3 inches.

The pulmonary function tests submitted for this claim all conform to the applicable quality standards except for the July 7, 2004 study conducted by Dr. Rasmussen. The July 7, 2004 study failed to identify the cooperation and comprehension levels of Claimant. (CX 1). However, the pre-bronchodilator study was non-qualifying, and I will therefore give it probative weight. The July 7, 2004 study post-bronchodilator was qualifying and cannot be given probative weight. The other studies conducted by Drs. Westerfield and Rasmussen will be given probative weight. (DX 10, 15). Therefore, out of the studies given probative weight only one study was qualifying and the other four were non-qualifying. Accordingly, I find per Section 178.204(b)(2)(i), Claimant has failed to establish total disability by a preponderance of the evidence.

B. Blood Gas Studies

Under Section 718.204(b)(2)(ii) total disability may be established with qualifying arterial blood gas studies. All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner or circumstances surrounding the testing affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated).

There are no arterial blood gas studies of record producing qualifying results. Accordingly, I find per Section 178.204(b)(2)(i), Claimant has failed to establish total disability by a preponderance of the evidence.

C. Cor Pulmonale

There is no medical evidence of cor pulmonale in the record, I find Claimant failed to establish total disability with medical evidence of cor pulmonale under the provisions of Section 718.204(b)(2)(iii).

D. Medical Opinions

The final way to establish a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. *Id*. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment.

20 C.F.R. § 718.204(b)(2)(iv).

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. In assessing total disability under Section 718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of Claimant's usual coal mine employment with a physician's assessment of Claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform comparable and gainful work pursuant to Section 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The physicians' reports are set forth above. In summary, Dr. Rasmussen performed an employment history finding Claimant worked thirty-one years in coal mine employment. (DX 10, CX 1). Dr. Rasmussen found that Claimant's last coal mine employment required him to lift heavy tools weighing between fifty and seventy pounds. He opined that Claimant's past employment history required him to perform heavy manual labor and some very heavy manual labor. Dr. Rasmussen opined that Claimant suffers from a moderate loss of lung function resulting in a moderate obstructive ventilatory impairment. He found Claimant was moderately impaired at exercise. Dr. Rasmussen opined that although Claimant only suffers from a moderate impairment, he does not have the pulmonary capacity to perform his last coal mine employment, which required heavy manual labor. Although Dr. Rasmussen's opinion of total disability is not consistent with the probative arterial blood gas studies and pulmonary function testing of record, he thoroughly examined Claimant and adequately took into consideration the exertional requirements of Claimant's last coal mine employment which required him to lift and carry over fifty pounds throughout the day. (DX 10, CX 1). Therefore, I find Dr. Rasmussen's opinions well-reasoned and well-documented and I give them great probative weight.

Dr. Robinette also opined that Claimant has an occupational lung disease resulting in an associated respiratory impairment and significant reduction of his diffusing capacity. (CX 2). However, the physician fails to state whether Claimant could perform his regular coal mine employment. Therefore, since Dr. Robinette fails to make a total disability finding, I give his opinion no probative weight.

In contrast, Dr. Fino opines Claimant has the capacity to return to coal mine employment. (DX 12). Dr. Fino found that Claimant worked thirty-two years in coal mine employment and noted Claimant last worked as a mechanic and running a buggy. Dr. Fino opined Claimant has a mild to moderate respiratory impairment. He states that Claimant's last coal mine employment did not involve heavy manual labor and therefore, Claimant retains the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. Although Dr. Fino lists two of Claimant's previous jobs (mechanic and buggy operator), he fails to explain the exertional requirements of these positions and how he determined there was no manual labor involved. (DX 12). As stated above, I have found that Claimant's last coal mine

employment did involve heavy manual labor, and therefore, I grant Dr. Fino's opinion less probative weight. (*See* DX 4).

Dr. Westerfield also opines Claimant has a respiratory impairment. (EX 1). In his report Dr. Westerfield fails to opine whether Claimant has the respiratory capacity to perform his regular coal mine employment. (EX 1). However, in his deposition testimony he opines that Claimant does have the respiratory capacity to perform his regular coal mine employment. Dr. Westerfield testified that he did not know whether Claimant's previous employment required him to perform heavy lifting (DX 15 p. 26) and stated that Claimant could not perform arduous labor. Therefore, since Dr. Westerfield failed to take into consideration the exertional requirements of Claimant's past coal mine employment and thereby based his opinion on his speculation that Claimant's employment did not involve heavy manual labor, I give his opinion little probative weight.

I find the well-reasoned and well-documented report of Dr. Rasmussen outweighs the less reliable reports of Drs. Fino and Rasmussen. Therefore I find Claimant has established total disability by the probative medical opinion reports of record under the provisions of Subsection 718.204(b)(2)(iv).

E. Overall Total Disability Finding

Upon consideration of all of the evidence of record, Claimant has established total disability. Accordingly, I find Claimant has established total disability under the provisions of Section 718.204(b). Therefore, Claimant has established a subsequent change in condition and I must now reopen the record and reconsider all the medical evidence of record in relation to all the elements of entitlement.

Pneumoconiosis and Causation

Section 718.202 provides four means by which pneumoconiosis may be established: chest x-ray, biopsy or autopsy, presumption under §§ 718.304, 718.305 or 718.306, or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a). The regulatory provisions at 20 C.F.R. § 718.201 contain a definition of "pneumoconiosis" provided as follows:

> (a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs

> and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a).

It is within the administrative law judge's discretion to determine whether a physician's conclusions regarding pneumoconiosis are adequately supported by documentation. *Lucostic v. United States Steel Corp*., 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *See King v. Consolidation Coal Co*., 8 B.L.R. 1-262, 1-265 (1985).

A. X-ray Evidence

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The chest x-rays in the record support a finding of pneumoconiosis. Dr. Westerfield, a B-reader, found the July 19, 2003 x-ray film positive for pneumoconiosis. Dr. Patel, a Board-certified radiologist and B-reader, found the August 5, 2003 x-ray film positive for pneumoconiosis; however, the x-ray was re-read as negative by Dr. Halbert, a Board-certified radiologist and B-reader. As such, I find that this x-ray does not support a finding of pneumoconiosis. Dr. Patel then found the July 8, 2004 x-ray film positive for pneumoconiosis. Dr. Robinette found the July 19, 2005 film positive for pneumoconiosis. Dr. Myers read the June 5, 1991 film as positive for pneumoconiosis. Then Dr. Baker, a B-reader, read the June 11, 1991 film as positive. Dr. Anderson read the June 12, 1991 film as positive. However, Dr. Poulos, a Board-certified radiologist and B-reader, found that the August 6, 1991 film showed no abnormalities consistent with pneumoconiosis. Dr. Lane, a B-reader, read the October 3, 1991 film as positive for pneumoconiosis. Dr. Baker read the March 9, 2001 film as positive and Dr. Fino, a B-reader, read the May 4, 2001 film as positive for pneumoconiosis.

Therefore the record includes one film read by a Board-certified radiologist and B-reader finding no pneumoconiosis, one finding of pneumoconiosis by a Board-certified radiologist and B-reader, four readings of pneumoconiosis by B-readers, and four other findings of pneumoconiosis. Accordingly, based on the qualifications of the reading physicians and the preponderance of positive x-ray readings, I find that pneumoconiosis has been established under § 781.202(a)(1).

B. Autopsy/Biopsy

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale, notwithstanding a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its well-documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a

medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*).

In Dr. Rasmussen's August 5, 2003 and July 7, 2004 reports he opined Claimant suffers from pneumoconiosis. (DX 10; CX 1). He based his opinions solely upon the readings of a chest x-ray and Claimant's history of dust exposure. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id*.

Acknowledging that Dr. Rasmussen performed other physical and objective testing, he listed that he expressly relied on Claimant's positive x-ray and coal dust exposure for his clinical determination6 of pneumoconiosis. (DX 10; CX 1). Moreover, he failed to state how the results from his other objective testing might have impacted his diagnoses of pneumoconiosis. As he does not indicate any other reasons for his diagnoses of pneumoconiosis beyond the x-ray and exposure history, I find his reports with respect to the diagnoses of clinical pneumoconiosis unreasoned and I give them little weight. (DX 10; CX 1). [19]

In addition, Dr. Rasmussen diagnosed Claimant with chronic obstructive pulmonary disease and emphysema in his August 5, 2003 report. (DX 10). Dr. Rasmussen related these conditions to coal dust exposure and smoking. He based his opinion on Claimant's chronic productive cough, airflow obstruction and reduced SBDLCO. Therefore, his diagnoses of chronic obstructive pulmonary disease and emphysema constitute a finding of legal pneumoconiosis. (DX 10). I give Dr. Rasmussen's legal pneumoconiosis opinion great weight.

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[19] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found that Claimant's complete pulmonary evaluation by Dr. Rasmussen is unreasoned for purposes of determining clinical pneumoconiosis as noted above. However, I have given his opinion as to legal pneumoconiosis and total disability great weight. Furthermore, the other evidence of record supports a finding of clinical pneumoconiosis. As a result, I find that a remand of this case would be futile. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see*, *e.g.*, *Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

Dr. Robinette also opined Claimant has pneumoconiosis based solely upon his own readings of a chest x-ray and Claimant's history of dust exposure. (CX 2). As indicated above, this basis alone does not constitute an adequate finding of pneumoconiosis. *See Cornett,* 227 F.3d at 576; *Worhach*, 17 B.L.R. 1-105, 1-110, and *Taylor*, 8 B.L.R. 1-405. Furthermore, Dr. Robinette performed other physical and objective testing but failed to explain how the testing impacted his diagnosis of pneumoconiosis. The physician also diagnosed Claimant with mild obstructive lung disease related to coal mine employment but he fails to opine that the condition is chronic. (CX 2). Therefore, I find Dr. Robinette's report with respect to a diagnosis of clinical and legal pneumoconiosis unreasoned and give it little probative weight.

Dr. Westerfield's report also concluded that Claimant has pneumoconiosis based solely on the chest x-ray evidence, and therefore for the reasons stated above, I find this opinion unreasoned. Dr. Westerfield also diagnosed Claimant with chronic obstructive pulmonary disease but he did not relate the condition to coal mine employment. Therefore, he made no finding of legal pneumoconiosis. I give Dr. Westerfield's pneumoconiosis opinion little weight.

In Dr. Fino's June 4, 2004 medical report he agrees that Claimant has pneumoconiosis. (EX 2). However, he never states a basis for his findings. A physician's report can be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, B.L.R. 1-1182 (1984). Therefore, I find this opinion unreasoned and undocumented and I give it little weight. However, Dr. Fino also opined that Claimant suffers from pneumoconiosis in his May 4, 2001 report. In this report he based his pneumoconiosis opinion solely on the chest x-ray evidence. Therefore, I also find this opinion unreasoned and I grant it little weight.

Drs. Myers, Anderson and Lane all diagnosed Claimant with pneumoconiosis. However, like the other physicians discussed above, they too only based their opinions on Claimant's chest x-rays and history of exposure. Drs. Myers and Lane also diagnosed Claimant with chronic obstructive pulmonary disease, but they did not relate these conditions to coal mine employment. Therefore, I find the opinions of Drs. Myers, Anderson and Lane unreasoned regarding clinical and legal pneumoconiosis and I grant them little weight.

In his June 11, 1991 report, Dr. Baker diagnosed Claimant with pneumoconiosis based solely on the chest x-ray evidence and Claimant's history of exposure. I find this opinion unreasoned and grant it little weight. Dr. Baker also diagnosed Claimant with chronic obstructive pulmonary disease but he failed to relate the condition to coal mine employment. Therefore, he made no finding of legal pneumoconiosis. However, in his March 9, 2001 opinion, Dr. Baker again diagnoses Claimant with chronic obstructive pulmonary disease based on the pulmonary function testing. Dr. Baker relates the chronic obstructive pulmonary disease to coal dust exposure. I find Dr. Baker's March 2001 opinion regarding legal pneumoconiosis well-reasoned and well-documented and I grant it great weight.

In contrast, Dr. Mettu opined that Claimant does not suffer from pneumoconiosis. He based his opinion on an x-ray reading finding no abnormalities consistent with pneumoconiosis. His opinion is supported by an x-ray reading in the record. I find his opinion is well-reasoned and well-documented. Dr. Mettu also diagnosed Claimant with chronic bronchitis, but he did

relate the condition to coal mine employment. Therefore, he made no finding of legal pneumoconiosis.

I have considered all the evidence under Section 718.202(a)(4) and I have granted the opinions of Drs Rasmussen, Baker and Mettu great weight. Therefore, I find Claimant has demonstrated, by a preponderance of the evidence, the existence of pneumoconiosis.

Overall Pneumoconiosis Finding

I have considered all the evidence under Section 718.202(a). Although Dr. Mettu provided a reasoned opinion finding Claimant does not suffer from clinical pneumoconiosis, I find the probative positive x-ray reports support a finding of clinical pneumoconiosis. I find the preponderance of the evidence supports a finding of clinical pneumoconiosis. Also the more complete, comprehensive and better supported medical opinion reports of Drs. Rasmussen and Baker support a finding of legal pneumoconiosis. Thus, I find Claimant has demonstrated, by a preponderance of the evidence, the existence of clinical and legal pneumoconiosis.

Causation of Pneumoconiosis

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether Claimant's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The burden is upon Claimant to demonstrate by a preponderance of the evidence that his/her pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

Id.

The miner was employed for twenty-one years in coal mine employment. Therefore, Claimant is entitled to the rebuttable presumption that his pneumoconiosis arose out of such employment. Since there is no evidence in the record to rebut this presumption, I find Claimant has proven that his pneumoconiosis arose out of his employment in the coal mines under 20 C.F.R. § 718.203(b).

Total disability

As stated above, the determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. The regulation at Section 718.204(b)(2) provides the following criteria to be applied in determining total disability: 1) pulmonary function studies; 2) arterial blood gas tests; 3) a cor pulmonale diagnosis; and/or, 4) a well-reasoned and well-documented medical opinion concluding total disability. I will reevaluate all the evidence in the record under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether

Claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

A. Pulmonary Function Tests

As indicated above, under Section 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests. To be qualifying, the FEV_1 as well as the MVV or FVC values, must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984).

In the pulmonary function tests of record, there is a small discrepancy in the height attributed to Claimant. In analyzing the pulmonary function test results, I shall utilize the average height reported for Claimant, 69.6 inches.[20] *See Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

Five of the pulmonary function tests of record fail to conform to the applicable quality standards. The tests conducted by Dr. Rasmussen on July 7, 2004 fail to state the cooperation and effort levels. The test post-bronchodilator is qualifying and therefore, will not be taken into consideration, but the test pre-bronchodilator is not qualifying and will be weighed as evidence. *See Crapp*, 6 B.L.R. 1-476. The tests performed by Dr. Myers on June 5, 1991 also failed to state the cooperation and effort levels; however, the tests are non-qualifying and will be taken into consideration. *See Id.* Dr. Baker's June 11, 1991 tests were qualifying, but they failed to state the cooperation and effort levels, so it cannot be taken into consideration. *See Id.* Dr. Lane's October 3, 1991 tests were also qualifying but the record does not contain three tracings from the study. Therefore, the reliability of Dr. Lane's test cannot be determined, and I will not take it into consideration. *See Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Dr. Baker's March 9, 2001 tests are qualifying and they comply with the quality standards, but he notes that Claimant exercised poor effort when performing the tests. Therefore, the tests will not be taken into consideration. Dr. Baker's April 5, 2001 tests were also qualifying. However, Dr. Burki invalidated the tests stating the equipment was unacceptable. Dr. Baker also noted in his report that the tests could not be reproduced. Therefore, I will give these tests less weight.

Accordingly, of the tests that will be considered, there are eight tests that produced non-qualifying results and there are three tests that produced qualifying results. Therefore, I find per Section 178.204(b)(2)(i), Claimant has failed to establish total disability by a preponderance of the evidence.

B. Blood Gas Studies

Under Section 718.204(b)(2)(ii) total disability may be established with qualifying arterial blood gas studies. All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after

[20] The average height is higher then the previous average height found because in my prior finding I only averaged the heights recorded in the newly submitted evidence.

exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner or circumstances surrounding the testing affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated).

There are no arterial blood gas studies of record producing qualifying values. Accordingly, I find per Section 178.204(b)(2)(I,), Claimant has failed to establish total disability by a preponderance of the evidence.

C. Cor Pulmonale

There is no medical evidence of cor pulmonale in the record, I find Claimant failed to establish total disability with medical evidence of cor pulmonale under the provisions of Section 718.204(b)(2)(iii).

D. Medical Opinions

The final way to establish a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. *Id*. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment. 20 C.F.R. § 718.204(b)(2)(iv). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

As discussed above, I found the medical opinions of Dr. Rasmussen well-reasoned and well-documented in relation to total disability. A medical opinion does not have to be wholly reliable or wholly unreliable; rather, the opinion can be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue. *See Drummond Coal Co. v. Freeman*, 17 F.3d 361 (11th Cir. 1994); *Billings v. Harlan #4 Coal Co.*, B.R.B. No. 94-3721 B.L.A. (June 19, 1997) (*en banc) (*unpub.). Accordingly, I divide Dr. Rasmussen's opinions into the relevant issues of clinical pneumoconiosis, legal pneumoconiosis and total disability. (DX 10). As noted above with respect to clinical pneumoconiosis, Dr. Rasmussen's report is not well-reasoned. However, in examining the issues of legal pneumoconiosis and total disability, I find Dr. Rasmussen's opinions well-reasoned and well-documented.

Also I gave the total disability opinions of Drs. Fino[21] and Westerfield little probative weight. Dr. Robinette's total disability opinion was afforded no probative weight since he failed to make a total disability finding. I give Dr. Mettu's opinion no probative weight for the same

[21] Dr. Fino's medical report filed in the second claim is also unreasoned as to total disability. (DX 2-54). In both reports he states Claimant's prior coal mine employment did not involve heavy manual labor. However, this statement is incorrect. As stated above, I find Claimant was required to lift over fifty pounds throughout the day which is considered heavy manual labor. Therefore, Dr. Fino failed to take into consideration the correct exertional requirements when formulating his opinions.

reasons. Dr. Mettu found that Claimant had a moderate pulmonary impairment, but he made no finding on whether Claimant could return to his previous coal mine employment. (DX 1-17).

Dr. Myers examined Claimant on June 5, 1991. (DX 1-38). He stated that Claimant worked thirty-one years in coal mine employment, loading and cutting coal and as a shuttle car operator. He opined that Claimant has a pulmonary impairment due to all his pulmonary conditions which enables him to perform his prior coal mine employment. However, Dr. Myers fails to discuss how he came to the opinion that Claimant was totally disabled despite the fact that his objective medical testing produced non-qualifying results. He also fails to discuss how the exertional requirements of Claimant's previous coal mine employment could have impacted his decision and how the pulmonary conditions prevent Claimant from being able to perform his regular coal mine employment. Therefore, I find his opinion unreasoned and give it little probative weight.

In his 1991 opinion, Dr. Baker opined that Claimant has a respiratory impairment related to coal dust exposure. (DX 1-31). He took an employment history of Claimant, finding Claimant worked thirty one years in coal mine employment operating the loading machine, cutting machine, roof bolter and shuttle car. Dr. Baker found that Claimant is unable to return to his previous coal mine employment. He states that Claimant should have no further exposure due to his pneumoconiosis, chronic obstructive pulmonary disease, chronic bronchitis and resting hypoxemia. Dr. Baker notes that Claimant would have a difficult time performing manual labor due to these conditions. I give Dr. Baker's opinion less weight for the following reasons. First, he provided no basis for his opinion besides the fact that he found Claimant suffers from pneumoconiosis, chronic obstructive airway disease, resting arterial hypoxemia and chronic bronchitis. An opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 BLR 1-83 (1988). Next, although the objective testing performed by Dr. Baker in 1991 produced qualifying values, the tests failed to conform to regulation requirements. Last, Dr. Baker's report states that Claimant could not perform the manual labor involved in coal mine employment; however, he never discusses the exertional requirements of Claimant's last coal mine employment or how Claimant's conditions would affect his ability to perform his previous coal mine employment. Therefore, I give Dr. Baker's opinion less weight.

Dr. Anderson found that Claimant worked thirty-one years in coal mine employment. (DX 1-25). He diagnosed Claimant with a moderate obstructive ventilatory defect. Dr. Anderson opined that Claimant does not have the respiratory capacity to perform all jobs in coal mine employment. However, Claimant does not have to be able to perform all jobs in coal mine employment. There only needs to be a finding that Claimant is unable to perform his last coal mine employment. Dr. Anderson fails to make a finding on whether Claimant could perform his last coal mine employment and he does not take into consideration Claimant's previous exertional requirements. Therefore, I find his opinion unreasoned and I give it less weight.

Dr. Lane also opined that Claimant does not have the pulmonary capacity to perform his past coal mine employment. (DX 2-129). He bases this opinion on his diagnosis of chronic obstructive pulmonary disease. He states that chronic obstructive pulmonary disease is the

reason for Claimant's pulmonary impairment as shown by the pulmonary function testing below 80% of predicted. However, the pulmonary function testing performed by Dr. Lane, while qualifying, failed to conform to regulation requirements. Furthermore, he does not attribute Claimant's chronic obstructive pulmonary disease to coal mine employment and even fails to state a basis for his diagnosis of chronic obstructive pulmonary disease. Therefore, I give his opinion less weight.

Dr. Baker submitted a second report based on his March 9, 2001 examination of Claimant. (DX 2-165). In this report, Dr. Baker also opined that Claimant's moderate pulmonary impairment prevents him from performing his regular coal mine employment. He based this opinion on his pulmonary function testing. However, although the March 9, 2001 pulmonary function testing produced qualifying results, Dr. Baker noted that Claimant exerted poor cooperation and effort when the test was conducted. Dr. Baker even notes in his opinion that the testing could not be reproduced. An administrative law judge should not discredit an opinion solely because of the physician's reliance on nonconforming testing; however, in this instance, Dr. Baker only listed the pulmonary function testing as the basis for his opinion. He did not indicate that he examined the exertional requirements of Claimant's previous job or other medical conditions. Dr. Baker provided no other reasoning for his conclusion. Therefore, I give his total disability opinion less weight.

I find that the well-reasoned and well-documented report of Dr. Rasmussen outweighs the other unreasoned and less reliable medical reports of record. Furthermore, Dr. Rasmussen's report is the only one that actually took into consideration the exertional requirements of Claimant's last coal mine employment. Therefore, I place great weight on his opinion. Accordingly, I find Claimant has established total disability by the probative medical opinion reports of record under the provisions of Section 718.204(b)(2)(iv).

Total disability due to Pneumoconiosis

A claimant must demonstrate total disability due to pneumoconiosis by a documented and reasoned medical report. *See* § 718.204(c)(2). In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). There is only one well-reasoned and documented opinion receiving great weight which finds Claimant is totally disabled due to coal dust exposure. Dr. Rasmussen's opinions were well-reasoned as to legal pneumoconiosis and total disability. He opined that Claimant's total disability is the result of coal dust exposure and smoking. Dr. Rasmussen states that both are contributing factors and that both cause similar lung tissue destruction and airway disease. However, he opined that based on his research, Claimant's coal dust exposure was a major contributing factor in his total disability. I find Dr. Rasmussen's opinion well-reasoned and well-documented. Therefore, I find that Claimant has established total disability due to legal pneumoconiosis.

ENTITLEMENT

In sum, the newly submitted evidence does establish a material change in condition upon which the prior claim was denied. When reevaluating all the medical evidence of record, I find Claimant has met all of the conditions of entitlement. Therefore, Mr. Hamilton's claim for benefits under the Act shall be granted.

Attorney's Fees

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director*, 8 BLR 2-1 (1985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is ordered that the claim of Leamon Hamilton for benefits under the Black Lung Benefits Act is hereby GRANTED.

A

JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).